FREEDOM OF INFORMATION REPORT

Facility Information		Audit Information	
Permit:	RTF-0014	**Audit Name:**	RTF ROV 20161020
Facility Name:	PALMETTO PEE DEE RESIDENTIAL TREATMENT CENTER	**Type:**	L07 Investigation
Address:	601 GREGG AVE STE B	**Start Date:**	28 Dec 2016 10:30 AM
City/State/Zip:	FLORENCE, SC 29501-4316 Florence	**End Date:**	28 Dec 2016 04:30 PM
Phone 1:	843-667-0644	**Inspector:**	Perry Davis
Email:	GREGORY.JOHNSON@UHSINC.COM		
Contact Name:	LAKESHIA COAKLEY		
Contact Email:	null		
Contact Phone:	803-348-2183		

Overall Score
0.0%

Report Notice

Question ID	Question	Answer
NOTICE01	Bureau of Health Facilities Licensing 2600 Bull St Columbia SC 29201-1708 REPORT NOTICE: If applicable, this Report of Visit includes a detailed description of the conditions, conduct or practices that were found to be in violation of requirements. This inspection or investigation is not to be construed as a check of every condition that may exist, nor does it relieve the licensee (owner) from the need to meet all applicable standards, regulations and laws. The South Carolina Code of Laws requires this Department to establish and enforce basic standards for the licensure (permitting), maintenance, and operation of health facilities and services to ensure the safe and adequate treatment of persons served in this State. It also empowers the Department to require reports and make inspections and investigations as considered necessary. Furthermore, the Code authorizes the Department to deny, suspend, or revoke licenses (permits) or to assess a monetary penalty against a person or facility for (among other reasons), violating a provision of law or departmental regulations or conduct or practices detrimental to the health or safety of patients, residents, clients, or employees of a facility or service. If applicable to the type of report being made, the signature of the activity representative indicates that all of the items cited were reviewed during the exit discussion. If this Report of Visit is required by regulation to be made available in a conspicuous place in a public area within the facility, redaction of the names of those individuals in the report is required as provided by Sections 44-7-310 and 44-7-315 of the S.C. Code of Laws, 1976, as amended.	Report Notice

Administrator's Signature - Plan of Correction

Question ID	Question	Answer
SIGN01	PLAN OF CORRECTION - Administrators Certification: I certify that the attached plan of correction describes: (1) the actions taken to correct each cited deficiency, (2) the actions taken to prevent similar recurrences, and (3) the actual or expected completion dates of those actions.	POC REQUIRED

	PRINT NAME:_____ TITLE:_____ SIGNATURE:_____ DATE:_____ Any violations cited in this report of visit were observed at the time of the inspection. The Administrator submits an electronic plan of correction by visiting the website http://www.scdhec.gov/Health /FHPF/HealthFacilityRegulationsLicensing/HealthcareFacilityLicensing/CorrectionPlan/ and following the instructions online. Or the Administrator returns a copy of this report (original signature required) with description of corrective actions to: SCDHEC, Bureau of Health Facilities Licensing, 2600 Bull St, Columbia, SC, 29201 Your response to this report must be received in our office by close of business (5:00 p.m.) no later than the date listed below: **Comments** • *The Plan of Correction is due 15 days after receipt of this report of visit.*	

Inspection Information

Question ID	Question	Answer
COMBO-LIC	Inspection Includes Licensing:	YES
COMBO-FOOD	Inspection Includes Food/Sanitation:	NO
COMBO-FLSC	Inspection Includes Fire & Life Safety:	NO
ONSITE	Is this an On-Site Visit?	YES
INSP	Select the Type of Inspection to be Performed:	RTF Complaint Investigation
COMPL-01	Section Team Log Number: **Comments** • *M12040-16*	Section Team Log Number
COMPL-03	Reason for Investigation: **Comments** • *A complaint received by the Department's Division of Health Licensing on 12/20/2016 was investigated. The complaint alleged that:* *(1). Staff Member A was written up for choking Resident E on* [redacted] *(2). Witnessed Staff Member B threatened residents in the Moultrie unit. A resident found a napkin with marijuana and gave it to Staff Member B and it was not reported to law enforcement.* *(3). Residents are being feed improperly and the facility cooks the food in a kitchen that not approved by DHEC.* *(4). The resident's do not have enough supplies to complete their daily hygiene or keep the facility clean.* *(5). Two residents on the Edisto unit was reported to have a staph infection and nothing was done in the past 3 weeks.* *(6). There is mold in the resident's rooms and in the hallway on the walls.* *(7). The bathrooms are unsanitary.* *(8). The facility was short staffed on 10/16/16.*	Reason for the Investigation.

	(9). The showers and the heating/cooling system is working improperly in the resident's rooms. The washing machines and dryers are broken. *(10). On [redacted] Resident C eloped from the facility.* *(11). Resident A and D was caught self harming him/herself when staff notified team lead.*	
COMPL-04	What is the Source:	Consumer Complaint
COMPL-10	Date Agency (DHEC) Notified: **Comments** • *12/20/2016*	Date Agency (DHEC) Notified:
COMPL-05	Detailed Results of this Investigation: **Comments** • *To investigate this complaint an unannounced visit was made to the facility by (4) representatives of the Department. This investigation consisted of: (1). A walk-through of the facility for housekeeping and maintenance issues. (2). A review of residents chart which included treatment plans, weekly nursing summary, nursing body audits, progress notes, daily monitoring sheets, incident/accident reports for the months of October and November, and medication administration records (MARs). (3). A review of the facility maintenance log. (4). A review of staff charts which included in-service training and corrective action reports. (5). A review of the facility policy and procedures which included elopement, infectious control, and staffing. (6). A review of the facility weekly food menu. (7). An interview with residents and staff members. (8). A review of the facility staffing schedule and clock in sheets.* *The following was ascertained:* *Allegation 1 was not cited. An incident report for allegation of abuse dated [redacted] documented that Resident E attempted to exit out of the back door of the cafeteria and was stopped by Staff Member A. The report stated "When I was trying to run, staff stepped in front of me and she hit me in my face and my elbow." Resident E was assessed by the nurse and there was no injuries noted. There was no documentation available for review indicating Staff Member A was written up for choking Resident E.* *Allegation 2 was not cited. Residents and staff members interviewed stated that Staff Member B has never threatened the residents on the Moultrie unit. Residents and Staff Members interviewed did not observe nor were they aware of any incident where a resident found a napkin with marijuana in it. There was no documentation available of the incident.* *Allegation 3 was cited.* *Allegation 4 was not cited. Hygiene products which included towels and toilet paper were observed on each unit in the supply closet for each resident. In a closed container for each resident,a list of supplies were available which included toothpaste, toothbrush, deodorant, and a comb/brush. Hygiene and cleaning products which included feminine pads, deodorant, gloves, floor cleaners and window cleaners were observed in a locked supply closet. The supply closet was accessible to the staff members located near the Administrator office.* *Allegation 5 was not cited. Staff members interviewed were unaware of any residents with a staph infection on the Edisto unit.* *Allegation 6 was not cited. There was no presence of a black substance observed throughout the facility.* *Allegation 7 was cited.* *Allegation 8 was cited.*	Detailed Results

	Allegation 9 was cited. *Allegation 10 was cited.* *Allegation 11 was cited.* ***As a result of this investigation, the following violations of R.61-103, Residential Treatment Facilities for Children and Adolescents, were cited.***	
COMPL98	Is this an Unlicensed Facility/Activity Complaint?	NO
COMPL-06	Has the Initial QI Review Been Completed?	NO
VERIFY02	Is the Current Facility/Activity Administrator the same as the Administrator of Record?	YES
INSP04	Are there any other individuals accompanying the auditor for this visit? **Comments** • *James Holmes, Ivey Wilkes, and Tkeyah Brunson*	YES

RTF Regulation Sections 100 - 400

Question ID	Question	Answer
R-61-103-400.A	400.A. Written policies and procedures addressing each section of this regulation regarding resident care, rights, and the operation of the facility shall be developed and implemented, and revised as required in order to accurately reflect actual facility operation. Each facility shall have a clear written statement of its purpose and objectives. This policy shall include a specifically delineated description of the services the facility offers, in order to provide a frame of reference for judging the various aspects of the program. The policy shall also include: (Class II Violation) **Comments** • *The written policy #CS042, titled Staffing Ratios with a procedure documenting that: The ratio of staff to residents during waking/program hours shall be a minimum of 1 staff to 5 residents. Waking/program hours are defined as those times the client is expected to be awake and receiving services which is usually from 6:00 am until 8:00 pm.* ***The facility policy was not implemented on the date of 10/16/16.*** *(1).A staffing sheet documented on 1st shift (8 am to 4 pm) for the Edisto Unit, a census of 21 residents with a staff of 3.* *(2). A staffing sheet documented on 1st shift (8 am to 4 pm) for the Savannah Unit, a census of 11 residents with a staff of 2.* *(3). A staffing sheet documented on 2nd shift (4 pm to 12 am) for the Edisto Unit, a census of 21 residents with a staff of 4.* *(4). A staffing sheet documented on 2nd shift (4 pm to 12 am) for the Savannah Unit, a census of 11 residents with a staff of 2.* ***The facility policy on staffing was not implemented on 10/16/16 with procedure #5 stating "Residents shall remain in sight and sound observation range of staff at all times. Staff shall conduct periodic visual welfare checks of all residents at intervals not to exceed every 15 minutes."*** *An incident report of attempted suicide that occurred around 2:35 pm when Resident A was found on the bedroom floor with a shirt around his/her neck and was turning blue in the face. Staff on duty notified the nurse and shift team leader and nurse obtained an order to send Resident A to the hospital for further evaluation. Resident A remained in the hospital overnight and returned to the facility on [redacted] and was put on suicide risk precaution.*	OUT (Repeat)

RTF Regulation Sections 500 -1300

Question ID	Question	Answer
R61-103-1002.A6	1002.A.6. Each resident shall be afforded the following rights: 6. The right to be free from harm, including isolation, excessive medication if applicable, abuse, or neglect; (Class II Violation) **Comments** • ***Resident was not afforded the following rights: The right to be free from abuse:*** *According to the incident report for physical confrontation with a female staff dated [redacted] Resident D stated "I walked into the cafeteria for lunch as I walking down the rail Staff Member A kept calling me stupid." Resident then stated that "Staff Member A got into my face and I pushed her and that's when she punched me in the face, grab my hair and hit my head on the rail." There were two witnesses present that separated the staff from the resident. The nursing body audit for Resident D dated [redacted] was reviewed and stated "faint bruise at inner aspect of right forearm; on the resident face, upper lip and Left cheek edematous, superficial scratch skin broken at center of forehead and superficial 2 scratches skin broken at bridge of nose. Resident D was sent to the hospital for further evaluation and returned diagnosed from the discharge summary with an Abrasion.*	OUT (Repeat)
R-61-103-1303.D	1303.D. The same foods shall not be repetitively served during each seven (7) day period except to honor specific, individual resident requests. (Class III Violation) **Comments** • *(1). For Week 2 of the facility menu available for review documented grilled ham and cheese for lunch on Tuesday and for dinner on Saturday.* *(2). For Week 4 of the facility menu available for review documented grilled ham and cheese for lunch on Tuesday and for dinner on Saturday.*	OUT
R-61-103-1303.E	1303.E. Specific times for serving meals shall be established, documented on a posted menu, and followed. (Class III Violation) **Comments** • *Specific times for serving meals was not documented or posted in the facility.*	OUT
R-61-103-1303.F	1303.F. Suitable food and snacks shall be available and offered between meals. (Class II Violation) **Comments** • *Snacks that were offered between meals for Weeks 1 through 4 were not suitable for the residents.* *(1). For breakfast, saltine crackers were offered as a snack.* *(2). For lunch and dinner, the snack menu stated "varies" and did not indicate the type of snack given.*	OUT
R-61-103-1306.A	1306.A. Menus shall be planned and written a minimum of one (1) week in advance and dated as served. The current week's menu, including routine and special diets and any substitutions or changes made, shall be readily available and posted in one (1) or more conspicuous places in a public area. All substitutions made on the master menu shall be recorded in writing. Cycled menus shall be rotated so that the same weekly menu is not duplicated for at least a period of three (3) weeks. (Class III Violation) **Comments**	OUT

	• *The facility menu's for Weeks 1 and 3 and for Weeks 2 and 4 was not dated as served nor posted in one or more conspicuous places in a public area.*	

RTF Regulation Sections 1400 - 2800

Question ID	Question	Answer
R-61-103-1600	1600. A facility shall keep all equipment and building components, such as doors, windows, lighting fixtures, and plumbing fixtures, in good repair and operating condition. A facility shall document all preventative maintenance. A facility shall comply with the provisions of the codes applicable to residential treatment facilities referenced in Section 1902. (Class III Violation) **Comments** • *The following maintenance issues were observed:* *(1). On the Savannah Unit, the cold water knob was observed missing from the sink in resident room 102.* *(2). On the Savannah Unit, a hole was observed in the wall in resident room 100.* *(3). In the Moultrie Unit, the cold and hot water knobs were observed missing from the sink in resident room 222 and could not be turned on.* *(4). On the Moultrie Unit, the cold water knob was observed missing from the sink in resident room 237.* *(5). On the Edisto Unit, the hot water knob was observed missing from the sink in resident room 281.* *(6). According to an incident report dated 10/11/16 documented that the fire doors or delayed egress doors were not functioning properly. Once the system and doors were assess, it was found that there was a defective power supply and a replacement part that had to be ordered.*	OUT (Repeat)
R61-103-1703.B1	1703.B.1. Interior housekeeping shall, at a minimum, include: 1. Cleaning each specific area of the facility; (Class II Violation) **Comments** • *The following housekeeping issues were observed:* *(1). Brown stains were observed on 5 ceiling tiles on the Savanna Unit near resident room 102.* *(2). Brown stains were observed on the ceiling tiles in the laundry room on the Savanna Unit.* *(3). Dead insects were observed in the light fixtures on the Santee Unit in resident's rooms 262, 266, and 268.* *(4). On the Moultrie Unit, an accumulation of dust was observed on the vent covers in resident's bathrooms 218, 224, and 234.* *(5). On the Edisto Unit, an accumulation of dust was observed on the vent covers in resident's bathrooms 211 and 279.* *(6). An accumulation of dust was observed on the vent covers in the Moultrie/Edisto group room.*	OUT

Record Retention

Question ID	Question	Answer
RETENTION	DHEC 0282 (05/2010) AUDIT - [Records Retention Schedule #SBH-F&S-17]	Retention

PLAN OF CORRECTION REPORTING FORM
BUREAU OF HEALTH FACILITIES LICENSING

INSPECTION INFORMATION

License Number:

RTF-0014

Facility Type:

HL- Residential Treatment for Children & Adolescents

Facility Name:

PALMETTO PEE DEE RESIDENTIAL TREATMENT CENTER

Inspection Date:

12/28/2016

Submission Date:

01/26/2017

Type of Inspection:

Investigation

ADMINISTRATOR'S CERTIFICATION

By checking this box, I attest that I am the administrator of the facility/activity and that this plan of correction is accurate. Additionally, I certify that the plan of correction describes the actions taken to correct each cited deficiency, the actions taken to prevent similar recurrences and the actual or expected completion date.

Checked

Administrator Name:

Lakeshia Coakley

E-mail:

lakeshia.coakley@uhsinc.com

Phone:

(803) 348-2183

RESPONSE TO CITATIONS

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
400.A.	Yes	01/31/2017

Corrective Action:

The facilities policies have been reviewed and found to be compliant with staffing ratio standards. In response to the DHEC finding in this area, Pee Dee Administrative team has reviewed its process for the documentation of Staffing Assignments. As a result of this internal review, it was identified that Staffing assignment sheets were not being monitored after each shift to ensure they correctly identify the number of employees actually working on each unit. This resulted in the discrepancy between names on the Staff assignment Sheets and the staff who were assigned to work on that unit. Upon review, it was determined that Pee Dee employed the correct number of employees to meet the needs of the youth as well as Pee Dee's internal minimum ratios of 1 staff to 5 residents on both Edisto and Savanah Unit during second shift on 10/16/16. The Staffing assignment sheets were also not being monitored after each shift to ensure they correctly identify the number of employees actually working on each unit. This resulted in the discrepancy between names on the Staff assignment Sheets and the staff who were assigned to work on that unit. New procedures have been implemented to ensure that the staffing assignments logs document a minimum of 1 staff to 5 residents during waking/program hours and 1 staff to 7 residents during sleeping hours. Third shift Staff Assignment logs will provide documentation that a minimum of 2 staff are on each unit at all times, with at least one male and one female staff present, awake, and available. Additional procedures that have been implemented include an expectation that staff members initial their names on the appropriate staff assignment log prior to leaving their shift . In addition, when assigned staff clock out, the Team Lead is responsible to ensure

that the relieving staff member's names are documented on the Staff Assignment log for that unit. Their names will be written by the appropriate staff member for whom they are providing relief. Staffing Assignment logs documentation training was provided by the Milieu Manager to the Team Leads on 01/06/17 and again on 01/13/17. An All staff meeting was conducted on 1/19/17 across all shifts where this procedure was communicated to all nonsupervisory staff.

Preventive Action:

Team Leads will be responsible to ensure the first quality level review of accuracy and completeness of the Staffing Assignment logs for his/her assigned shift. The Milieu Manager will review staffing assignment logs daily (across all three shifts) to ensure staff to client ratios are observed and also documented. In addition, the Executive Director will now provide quality monitoring of this process daily by comparing the Staffing Assignment sheets to the punch clock forms . Any errors found will be shared with Leadership Team during the daily flash meeting and follow documented in terms of retraining or coaching to correct the error. Errors in Staffing Assignment logs will be collected for ongoing performance improvement. Staffing Assignment logs will be included as part of the New Employee orientation training process to ensure all employees are aware of required ratio prior to working . A copy of the written procedure on Staffing Assignment sheets will be provided to all employees and copies placed in the staff break room and Milieu Manager's Procedure binder by 1/31/17.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1002.A.6	Yes	01/31/2017

Corrective Action:

Palmetto Pee Dee will ensure that each resident will be afforded the following rights: …6. The right to be free from harm, including isolation, excessive medication if applicable, abuse, or neglect. Staff member A was terminated on [redacted] as a result of the incident involving Resident D. This Human Resource action is in accordance with internal policy and procedure, Employee Conduct and Work Rules, Policy # 15.01. The program is re-vamping its New Employee Orientation training to provide additional emphasis on working with the population served (i.e. Boundaries, Working with Residents with Developmental Delays and the Nonverbal Population). Effective with the 02/06/17 NEO training, "Positive Discipline" will be added to the training curriculum. Additionally, staff training is provided each month during All Staff meetings with an on-going focus of working with positive discipline.

Preventive Action:

Human Resources will continue to take appropriate action on any employee found to be non-compliant with employee conduct and work rules. The program will continue to ensure resident's rights in the following ways: discussions/alerts of resident behaviors during daily shift briefings (led by Team Leads), discussions/alerts of high risk behaviors during daily Rounds meetings, Special Incident Review meetings held weekly or more frequently as needed, to address high risk behaviors/incidents. Clinical therapists will provide additional direct care staff training each month during All Staff training, beginning 01/31/17. Such training will focus on the population served and also address conflict resolution and de-escalation techniques.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1303.D	Yes	02/04/2017

Corrective Action:

The program will ensure that the same foods shall not be repetitively served each 7 day period, except to honor specific, individual resident requests. The menu has been revamped to ensure that no food is served twice in one 7 day period. The Director of Plant Operations will provide individual staff training to Dietary staff by 02/04/17 to ensure staff adheres to the assigned menu. The Registered Dietitian (RD) will provide the program with the new 2017 Menu Guide and Low Sodium Menu Guide by February 3, 2017.

Preventive Action:

The RD will provide oversight with menu planning and sign off on all menus. Assigned menus will be reviewed by the Plant Operations Manager each week to ensure adherence by dietary staff.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1303.E	Yes	01/31/2017

Corrective Action:

On the day of the on-sight visit 12/28/16, there was no posted menu in the cafeteria, as it had been removed for painting. The program has re-posted the menu schedule of posted menu(s) with serving times in clear view of residents and staff by the cafeteria door.

Preventive Action:

Procedures have been implemented to ensure that assigned Dietary Staff review menus weekly, as evidenced by their initials. The Director of Plant Operations will review the menu weekly. This inspection criterion will be added to the Plant Operations EOC Rounds form by 01/31/17.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1303.F.	Yes	01/31/2017

Corrective Action:

In consultation with the Registered Dietitian, dietary staff made changes to the snack options offered between meals. Saltine crackers have been removed from the snack menu. Specific snack items are now included on the weekly menu to ensure that suitable snacks are available and offered between meals. In addition to specific snack items, fresh fruit is always made available and encouraged. A list of suitable snack items will be maintained and reviewed routinely by the RD.

Preventive Action:

The RD will review and provide input with respect to snack choices. Staff who provide snacks to the residents on the units (Team Leads) and Dietary staff will be trained on new snack choices and where snacks will be housed by 01/31/17. The Director of Plant Operations will ensure adherence to suitable snacks by reviewing and documenting snack choices provided to residents each week. The documentation will be maintained in a binder in the office of the Director of Plant Operations.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1306.A	Yes	02/04/2017

Corrective Action:

The program will ensure that menus are planned and written a minimum of one week in advance and dated as served. The current week's menu (to include routine, special diets and/or substitutions) shall be readily available and posted in the cafeteria. Cycled menus shall be rotated so that the same weekly menu is not duplicated for at least a period of 3 weeks. The Director of Plant Operations will provide individual staff training to Dietary staff by 02/04/17 to ensure staff adheres to the assigned menu. The Registered Dietitian (RD) will provide the program with the new 2017 Menu Guide and Low Sodium Menu Guide by 02/03/17.

Preventive Action:

The RD will review and provide oversight with menu planning. Assigned menus will be reviewed by the Plant Operations Manager each week to ensure adherence by dietary staff. In the event that an emergent issue results in a needed change to the menu, reasons for the change will be documented and posted for staff and residents to see. Copies of previous weeks' program menus will be maintained in a binder in the office of the Director of Plant Operations.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):

1600	Yes	01/19/2017

Corrective Action:

The facility will keep all equipment and building components, such as doors, windows, lighting…in good repair and operating condition. The facility will document all preventative maintenance and comply with the provisions of the codes applicable to residential treatment facilities. On the day of the on-sight visit, several maintenance issues were observed. As of 01/19/17, knobs on sink were replaced and hole in wall repaired on Savannah Unit; knobs in sinks and water access in residential sink were repaired on Moultrie Unit; knobs in sink replaced on Edisto Unit. It was noted in an incident report dated 10/11/16 that the fire doors were not functioning properly as a result of a defective power supply. Please be advised that the program instituted a “Fire Watch” on 10/12/16 and carried out on all shifts, as evidenced by hourly documentation housed in Plant Operations. The “Fire Watch” remained in effect until such time as the fire alarm system was back on-line, on 10/13/16. At no time were residents and/or staff left without an approved alternate safety plan.

Preventive Action:

The program will conduct weekly Leadership Rounds and document and report any and all maintenance issues observed to Plant Operations. Plant Operations will continue to conduct weekly facility tours and ensure that work orders are completed within a timely basis. The results of all findings will be shared in Leadership with follow-up provided on completed repairs during daily FLASH meetings. Evidence of completed repair work documentation will be maintained by the Director of Plant Operations. All staff will receive retraining on the importance of submitting written work orders for items observed in need of repair as well as the need to contact supervisors regarding maintenance issues that affect patient safety during monthly All Staff meetings. This will also be reinforced during morning Rounds meetings and shift briefings.

Optional Comments:

Response Approved:

Yes

Section:	Was Completion Date Provided?	Completion Date (Actual or Expected):
1703.B.1	Yes	01/27/2017

Corrective Action:

The facility will ensure that interior housekeeping includes cleaning each specific area of the facility. On the day of the on-sight visit brown stains were observed on several ceiling tiles, dead insects were observed in the light fixtures in several residents’ rooms, and an accumulation of dust was observed on the vent covers in several residents’ bathrooms, and on the vent covers of one group room. As of 01/12/17, noted light covers were cleaned, ceiling tiles replaced and vents vacuumed. These items were added to the Daily Cleaning log to ensure ongoing cleaning of these areas moving forward.

Preventive Action:

Members of Leadership will conduct weekly Leadership Rounds and document/ report any and all maintenance issues observed to Plant Operations. Plant Operations will continue to conduct documented weekly facility tours and ensure that the interior of the facility receives routine cleaning. Housekeeping staff have been instructed regarding the new procedures of vacuuming vents and cleaning light fixtures at minimum every two weeks. The facility will add “vacuuming vents” to the Plant Operations check sheet and develop an interior housekeeping staff schedule, to ensure ongoing compliance with standards. The results of all facility inspection findings will be shared in Leadership with follow-up provided on completed repairs and/or additional cleaning during daily FLASH meetings. Evidence of completed repair work documentation will be maintained by the Director of Plant Operations.

Optional Comments:

Response Approved:

Yes

LOG INFORMATION SECTION

Report of Visit Delivery Date:

Plan of Correction Due Date:

Date Plan of Correction was Reviewed:

02/03/2017

Reviewed by:

L. Sanders, LPN

Comments:

Plan of Correction Approved:

Decision By:

Decision Date:

Remove POC:

UPLOAD DOCUMENTS

File Upload

Plan of Correction Log Number:

MPC01056-17